**Request for the Knowsley Neurodevelopmental Pathway (NDP)**

Version: July 2022

**Guidance for educational establishments and other professional referrers:**

**Who is this form for?**

For professionals to refer children and young people for an assessment of Autism Spectrum Disorders (ASD) **only.**

Attention Deficit Hyperactivity Disorder (ADHD) referrals need to be made to the Alder Hey ADHD Service. Go to: <https://alderhey.nhs.uk/services/adhd-service?q=%2Fservices%2Fadhd-service>.

**Eligibility**

* ASD referrals for children as young as 3 can be accepted, but early years children should be reviewed by the Child Development Team first. If the child is in Reception or below and is not known to the Child Development Team, please refer to them first. For more information on this, please visit: <https://www.knowsleyinfo.co.uk/content/child-development-team>.

* Young people aged 18 and above will not be accepted and need to be referred to adult services.
* If urgent support or treatment is needed for a child in crisis, a referral to the NDP is not appropriate. If your concern is regarding mental health, please contact CAMHS Duty. Or, if this is a physical or mental health related emergency, please call 999 or go to A&E.

**How do I make a referral?**

Referrals can be made by completing this form with any relevant attachments and sending via email to [Knowsley.NDP@nhs.net](mailto:Knowsley.NDP@nhs.net). If you need help with this form, please contact the Knowsley Referral Management Service at Clinical Partners on **0203 905 9390.**

**What should a good referral look like?**

We aim to ensure that families and young people are directed to the right service. To do this efficiently, a good referral should provide:

* **A clear summary of your concerns –** What is the problem? Who does it affect? What is the severity of the problem according to you, the parent/carer and child?
* **Other relevant details** – What, if any, information might be of relevance? For example, risky behaviour, significant life events, other diagnoses.
* **Information on risk –** is the child/young person’s safety or wellbeing at risk? Are you aware of any safeguarding concerns past or present? Do they engage in any risky behaviour? Do they harm themselves or others? Do they abuse drugs or take part in criminal behaviour?
* **Evidence from at least two settings -** Are the problems present in more than one setting (home, school, after school activities/clubs)? Please try to provide evidence from parent/carer as well as from school or from another professional who knows the child/young person well.
* **A summary of care –** What services or professionals are, have been or plan to be involved? Were they helpful? If these services or professionals have provided evidence/reports, please attach to this referral

Please note that referrals with incomplete or insufficient information will be returned and can delay the child/young person being accepted onto the NDP.

**Part 1 - Referrer to complete:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date of Referral:** | | | | | |
| **Child’s Details:** | | | | | |
| Name: |  | | | | |
| Date of Birth: |  | Gender: |  | | |
| NHS number: |  | | | | |
| Address: |  | | | | |
| Ethnicity:  Please tick or circle | **White**/White British  Black/Black British  Asian/Asian British  **Mixed**  **Other ethnic group, please describe:**  Would prefer not to say | | | | |
| First Language: |  | Interpreter needed? | Yes No | | |
| Disability/Medical needs? | Yes No  If Yes, please provide detail: | | | | |
| Adopted? | Yes No Year Adopted: | | | | |
| Looked After Child? | Yes No Name of Social Worker: | | | | |
| Child Protection Plan? | Yes No Name of Social Worker: | | | | |
| Child in Need? | Yes No Name of Social Worker: | | | | |
| Early Help? | Yes No | | | | |
| Education Health and Care Plan? | Yes No | | | | |
| Returner to the pathway? | Yes No | Date previously referred: |  | | |
| **Parent/Carer Details:** | | | | | |
| Name: |  | Relationship to child: | |  | |
| Address (if different to child): |  | | | | |
| Mobile: |  | Home/Alternative phone: | |  | |
| Email: |  | | | | |
| Interpreter needed? |  | Language: | |  | |
|  | | | | | |
| Name: |  | Relationship to child: | |  | |
| Address (if different to child): |  | | | | |
| Mobile: |  | Home/Alternative phone: | |  | |
| Email: |  | | | | |
| Interpreter needed? |  | Language: | |  | |
| **Parent/Carer Consent:**  Has parent/carer consented to share their details and their child’s details with the NDP?  Please tick:  Has parent/carer consented to the ND pathway contacting their child’s school, their GP and other professionals involved in their care?  Please tick:  Note: Consent **must** be given before you refer. | | | | | |
| **Referrer Details:** | | | | | |
| Name of referrer: |  | Designation of referrer: | | |  |
| Address of referrer: |  | | | | |
| Phone: |  | Email: | | |  |
| Signature of referrer: |  | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **GP Details:** | | | |
| Name of GP: |  | | |
| Name and address of GP surgery: |  | | |
| **School/Nursery Details (if different to referrer):** | | | |
| School: |  | SENCo/teacher: |  |
| Phone: |  | Email: |  |
| **Reason for Referral:** | | | |
| Please confirm that this referral is for an assessment of Autism Spectrum Disorders (ASD):  Autism Spectrum Disorders (ASD) ☐ | | | |
| **Briefly explain your reasons for making this referral.**  Please see Part 2 to provide more detailed information about your concerns. | | | |  |

**Part 2 – SENCo or other professional to complete (must know child well):**

|  |
| --- |
| Name and designation of professional:  **Are these concerns from your own observations?**  **When completing this form, please specify where these concerns relate to your own observations, and where they relate to parent/carer’s account.** |

**Please describe your concerns regarding this child or young person’s:**

1. **Social interaction** (awareness of others / interest in people / seeking comfort / giving comfort / empathy / building friendship / turn taking / eye contact / gesture / inappropriate behaviour).
2. **Social communication** (use of language for range of functions / topic selection / selection and maintenance of conversation /awareness of listener / vocabulary development / voice control, tone, volume, rate, expression / response to interaction / understanding of complex and non-literal language /understanding of gesture, tone and facial expression.)
3. **Flexibility of thought** (pretend play / imagination / need for routine / resistance to change /repetitive or stereotyped behaviour / obsessions or movements / all consuming interests)
4. **Attention, hyperactivity and impulse control** (attention and concentration / focus on task / hyperactivity, fidgeting, frequent body movements / forgetfulness / daydreaming / emotional dis-regulation / lack of sense of danger / organisational skills / peer relationships / oppositional behaviour)
5. **Language** (level of understanding, speech clarity, expressive language skills, selective mutism, fluency (stammering)).
6. **Sensory** (dislike or avoidance of certain sensations e.g. noise, light, texture, and/or sensory seeking behaviours e.g. touching certain textures, spinning)
7. **Physical health** (diagnosed conditions, treatment, medications, hospital admissions, impact, sleep)
8. **Learning / development** (school performance, attendance etc)
9. **What strategies are you currently using to support this child?** Please attach evidence of evaluation and plans put in place to target issues, EHCPs and any other relevant information.
10. **Family circumstances** (bereavements, marital breakdown, parental mental health / domestic violence / social care involvement / alcohol / addiction, SEN etc.)
11. **Anything else you would like to tell us?**
12. **Please detail any other support the child, family or school are accessing in the table below. Please also indicate if a report is available and attach to referral if possible.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Agencies involved or assessments completed:** | | | |
| **Agency/Assessment** | **If yes, please tick:** | **Contact Details** | **Report/s available? Y/N (if possible, please attach)** |
| Speech and Language Therapy |  |  |  |
| Occupational Therapy |  |  |  |
| Education Psychology |  |  |  |
| EHCP |  |  |  |
| Community Paediatrician |  |  |  |
| CAMHS (Child and Adolescent Mental Health) |  |  |  |
| CDT (Child Development Team) |  |  |  |
| Social Care/Family First? |  |  |  |
| Autism Advisory Teacher |  |  |  |
| School Nurse |  |  |  |
| Health Visitor |  |  |  |
| Early Help |  |  |  |
| Behaviour Support/Outreach |  |  |  |
| Other services |  |  |  |

**Part 3 – Parent/Carer to complete:**

If you need help with this form, please ask your child’s SENCo or another professional involved to support you. Alternatively, you can contact the Knowsley Referral Management Service on 0203 905 9390 or by emailing: [knowsley.ndp@nhs.net](mailto:knowsley.ndp@nhs.net)

Parent/Carer name:

**Please answer the following questions about your child as best as you can, and please include details:**

1. When were you first concerned about your child? Briefly detail your child’s development and your main concerns.
2. Is there anything unusual about your child’s use of language or how they speak?
3. Does your child get on with other children and adults? Do they have friends?
4. Does your child like struggle to cope with change? Do they like routine?
5. Does your child struggle to concentrate? Are they forgetful? Are they able to follow instructions?
6. Is your child more active than other children? Do they fiddle or move around constantly?
7. Does your child struggle to control their emotions or behaviour?
8. Does your child avoid or dislike certain sensations e.g. noise, smell, light, texture, particular foods? Or do they like or seek out certain sensations e.g. unusual movements such as spinning, peering at objects, feeling textures?
9. Who does your child live with? Do your child’s difficulties make day to day life difficult at home?
10. Has your child experienced any significant life events e.g. parent separation, bereavement?
11. Do you or anyone else in your family have a diagnosis of Autism, ADHD, Learning Difficulties or other mental health difficulties?
12. Anything else you would like to tell us?

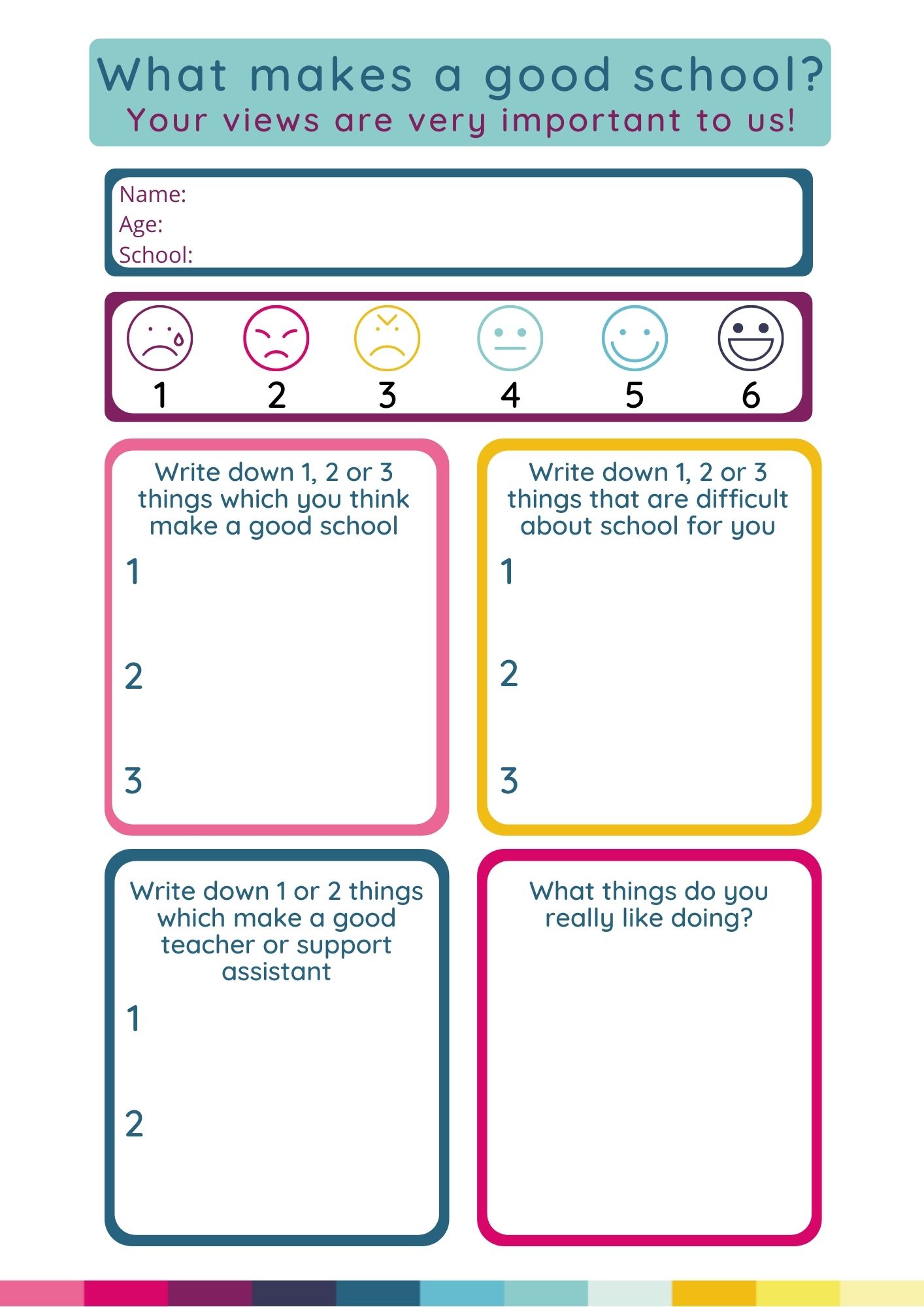
**Part 4 for child/young person to complete:**

**Part 4 of the referral form is optional. If this child or young person finds it difficult to complete this section, please leave it blank**.

Please ask the child or young person to write down or draw some of their own thoughts about their strengths and difficulties. You can use additional paper.

Alternatively, they can use the faces form on the next page.

1. What is going well for you at school and at home?
2. What is difficult for you at school and at home?



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